MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07484

Reg. Dist. No. 350

1. PLACE OF DEATH:
County Worcester
City or town Rural, Pocomoke City Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 Years.
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Worcester
City or town Rural Pocomoke Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Nellie M. Brittingham

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife Grover C. Brittingham
6.(c) If alive, give age 63 years
7. Birth date of deceased (mo., day, yr.) August 25 - 1888

8. AGE: Years	Months	Days	If less than one day
58	11	25	....hrs. ....min.

9. Birthplace Stockton, Worcester maryland (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name George L. Mason
13. Birthplace Maryland

MOTHER
14. Maiden name Ellen Dickerson
15. Birthplace Maryland

16. Informant Mrs. Grover C. Brittingham
Address Rural Pocomoke City Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof August 22-1947 (month) (day) (year)
Cemetery or crematory Baptist Cemetery
Location Pocomoke City Md.

18. Funeral director Henry S. Watson
Address Pocomoke City Md.

19. Aug. 21, 1947 (Date rec'd by registrar) Anne E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20 1947, at 4:9 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1942, to Aug 20 1947
and that I last saw her alive on Aug 19 1947

Immediate cause of death	DURATION
Arteriosclerosis	4 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE [illegible] M. D. or other
Address [illegible] Date signed 9-2-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07485

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 351

PRINT PLAINLY IN BLACK INK

1. PLACE OF DEATH:
County: Worcester
City or town: Snow Hill
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 37 years
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Snow Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) Il veleran, name war: No

3.(a) FULL NAME: Hennie P Carter

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Levin L. Carter
6.(c) Il alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 17 - 1863

8. AGE:

Years	Months	Days	Il less than one day
84	4	0	..... hrs. ..... min.

9. Birthplace: Snow Hill Worcester Md
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own Home

FATHER
12. Name: James A. Dickerson
13. Birthplace: Maryland

MOTHER
14. Maiden name: Priscilla Purnell
15. Birthplace: Maryland

16. Informant: Ollie Carter
Address: Snow Hill Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 20/47 (month) (day) (year)
Cemetery or crematory: Whatcoat
Location: Snow Hill Md

18. Funeral director: Elay O. Purnell
Address: Snow Hill Md

19. 8/19/1947 (Date rec'd by registrar) LeRoy Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 17 19 47 at 11 53 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 19 45 to Aug 18 19 47 and that I last saw h alive on Aug 17 19 47

Immediate cause of death		DURATION
	Cerebral Vascular Accident	2 wks.
Due to	Hypertensive Cardiovascular Renal syndrome	10 yrs.
Due to		
Other conditions	Gall Bladder disease	3 yrs

(Include pregnancy within 3 months of death)

Major findings at operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: Il death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Robert L. LaMar, MD
M. D. or other
Address: Snow Hill Date signed: 8-18-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

67486

Reg. Dist. No. 355

1. PLACE OF DEATH:

County: Worcester

City or town: Dyna[illegible] near Berlin
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Worcester

City or town: Berlin R.F.D. 2
(If outside city or town limits, write RURAL and give nearest town)

Street No.: no
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: George W Collick

3.(b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	a.a.	Married

6.(b) Name of husband or wife: Margaret Collick

6.(c) If alive, give age: Not known years

7. Birth date of deceased (mo., day, yr.): about 1874

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
about 73				

9. Birthplace: Dyna[illegible]
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Same as above

FATHER — 12. Name: William Collick

FATHER — 13. Birthplace: Snowhill

MOTHER — 14. Maiden name: Kathryn Collick

MOTHER — 15. Birthplace: Snowhill, md

16. Informant: Mrs Margaret Collick

Address: Berlin md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: aug 12-47 (month) (day) (year)

Cemetery or crematory: Family

Location: Dyna[illegible] near Berlin md

18. Funeral director: James R Stewart

Address: Salisbury md

19. 8-11-1947 (Date rec'd by registrar) Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8 Aug 19 47 at 2 30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 June 19 47, to 8 Aug 19 47

and that I last saw h[illegible] alive on 8 Aug 19 47

Immediate cause of death	DURATION
Chronic Degeneration	
Myocardium Fa Dropsy	10 y
Due to Arteriosclerosis	
Hypertension	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. A. Lankford M. D. or other

Address: Berlin, Md Date signed: 11 Aug 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Ink correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(I)

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

67487 P.

CERTIFICATE OF DEATH

Reg. Diat. No. .....

1. PLACE OF DEATH:

County Worcester

City or town Ocean City

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? unknown

Hospital, institution, or street address where death occurred:

Roosvelt Hotel

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3311 Longview Avenue —

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME David Dragon

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife Mary

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
48			..... hrs. ..... min.

9. Birthplace Balto Md

(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Israel

13. Birthplace Russia

MOTHER 14. Maiden name .....

15. Birthplace Russia

16. Informant Wife

Address .....

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-17-47 (month) (day) (year)

Cemetery or crematory Woodlawn

Location Rhd Rd & Hamilton Ave

18. Funeral director Jack Lewis Inc

Address 210 Eutaw Ave

19. Aug 18 19 47 (Date rec'd by registrar) A. W. Bodmer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15 19 47 at 6.10 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from — 19 ..... to — 19 .....

and that I last saw h ..... alive on ..... 19 .....

Immediate cause of death	Coronary Thrombosis	DURATION Instant
Due to		
Due to		
Other conditions		

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE John L. Riley Dep. Med. Exam. M. D. or other

Address Snow Hill, Maryland Date signed Aug. 15, 1947.

VS-A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07488

Reg. Dist. No. 351

1. PLACE OF DEATH:
County: Worcester
City or town: Newark Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred: no
How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Newark
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: James Hammond

3.(b) Social Security Number: Lost

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	a.a.	married

6.(b) Name of husband or wife: Nancy Hammond
6.(c) If alive, give age: 5 not known years

7. Birth date of deceased (mo., day, yr.): about 1872

8. AGE: Years	Months	Days	If less than one day
about 75			hrs. min.

9. Birthplace: Newark, Worcester Co. Md.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Same as above
FATHER 12. Name: Amos Hammond
13. Birthplace: Newark, Maryland
MOTHER 14. Maiden name: Unknown
15. Birthplace: Unknown
16. Informant: Mrs. Marjorie Foreman
Address: Berlin, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-4-'47 (month) (day) (year)
Cemetery or crematory: Cedar Chapel
Location: Newark, Maryland
18. Funeral director: James F. Stewart
Address: 402 E. Church St. Salisbury Md.
19. 8/4/ 1947 (Date rec'd by registrar) R. Ray Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8-1-47 19 at 9:30 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-1-36 19 to 8-1-47 19
and that I last saw h[illegible] alive on 7-25-47 19
Immediate cause of death: Chronic Ost. Nephritis — DURATION
Due to: Hypertension
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Illness Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Clifford E. Schott M. D.
Address: Berlin Md Date signed 8-1-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

55 b 07489

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH:
County Worcester
City or town Pocomoke City Rural #3
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Worcester
City or town Pocomoke City Rural #3
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war No

3. (a) FULL NAME Samuell Harrell
3. (b) Social Security Number None

4. Sex Male
5. Color or race Colored
6.(a) Single, married, widowed, or divorced Single
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) Nov. 16 – 1882

8. AGE:

Years	Months	Days	If less than one day
64	9	8	hrs. min.

9. Birthplace North Carolina
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business
FATHER 12. Name John Harrell
13. Birthplace North Carolina
MOTHER 14. Maiden name Unknown
15. Birthplace "
16. Informant Melvina Collins
Address Pocomoke City Md Rural #3
17. Burial Date thereof Aug. 27/47
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Baptist
Location Snow Hill, Md
18. Funeral director Olae E. Dennis
Address Snow Hill, Md
19. Aug 26 1947 Anne E. White
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24 1947, at 10:55 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mch 25 1946, to Aug 4 1947
and that I last saw him alive on Aug 4th 1947

Immediate cause of death.	DURATION
Large Sacral tumor	1½ yrs
Due to. Probably Sarcoma	
Due to. Injury	
Enlarged Prostate	DK
Other conditions. Diastolic Prolapse hernia	DK

(Include pregnancy within 3 months of death)
Major findings of operations.
Date of op.
Autopsy results.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. E. Sartorius M. D. or other
Address Pocomoke City Md. Date signed 8/24/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

07490

CERTIFICATE OF DEATH

Reg. Dist. No. 355

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Worcester
City or town: Berlin R F D (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md County: Worcester
City or town: Berlin R F D (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: William Bassett Hastings

3. (b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Dora Hastings
6.(c) If alive, give age: 58 years
7. Birth date of deceased (mo., day, yr.): June 12, 1882
8. AGE: Years 65 Months 2 Days 15 If less than one day ... hrs. ... min.
9. Birthplace: Berlin Wor Co. Md. (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business
FATHER 12. Name: James Hastings
13. Birthplace: Md
MOTHER 14. Maiden name: Mary A. Giffin
15. Birthplace: Berlin Md
16. Informant: Mrs W. B. Hastings
Address: Berlin Md R F D
17. Burial (Burial, cremation, or removal, Which?) Date thereof: 8/29/47 (month) (day) (year)
Cemetery or crematory: Evergreen
Location: Berlin Md.
18. Funeral director: Henry A. Burbage
Address: Berlin Md.
19. 8-29 1947 (Date rec'd by registrar) Helen L. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 27th 1947 at 2:30 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 June 1947, to ... 19...
and that I last saw h.im alive on ... 19...

	DURATION
Immediate cause of death: chronic degenerative Myocarditis	
Due to: atherosclerosis –	6 yrs
Due to	
Other conditions: Neuritis, & arthritis, senile – (Include pregnancy within 3 months of death)	

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: Herman L. Hubbard [illegible] M. D. or other
Address: Berlin, Md Date signed: 29 Aug 47

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

07491

Reg. Dist. No. 350

1. PLACE OF DEATH:
County Worcester
City or town near Pocomoke City
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 years
Hospital, institution, or street address where death occurred:
—
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Worcester
City or town near Pocomoke City
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Simon Holly

3.(b) Social Security Number 196-14-0844

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col'd	Single

6.(b) Name of husband or wife —
6.(c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) —

8. AGE: Years	Months	Days	If less than one day
Apprx. 60	—	—	....hrs. ....min.

9. Birthplace Unknown (Town, county, and state)
10. Usual occupation "
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden name "
15. Birthplace "

16. Informant Mr. Clarence Fleming
Address Pocomoke Md.

17. Burial Date thereof Aug 4 1947
(Burial, cremation, or removal) (Which?) (month) (day) (year)
Cemetery or crematory Hale Hill Cemetery
Location Rural Pocomoke Md.

18. Funeral director Henry H. Watson
Address Pocomoke Md.

19. Aug. 4, 1947 Anne E. White
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 3 1947, at 1 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19..., to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Progressed degeneration of heart	unknown
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE John L. Riley Dep. Med Exam
M. D. or other
Address Snow Hill Md. Date signed 8/3/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

67492

462

CERTIFICATE OF DEATH

Reg. Diat. No. 355

1. PLACE OF DEATH:

County Worcester

City or town Ocean City Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Worcester

City or town Ocean city Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No. Dorchester & Latrobe ave
(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME Mattie Kelley

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Married

6.(b) Name of husband or wife Willie Avery Kelley

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) aug 8 1897

8. AGE: Years	Months	Days	If less than one day
50	1	—	____ hrs. ____ min.

9. Birthplace Chincoteague Va
(Town, County, and state)

10. Usual occupation Housewife

11. Industry or business —

FATHER 12. Name Daniel Watson

13. Birthplace Chincoteague Va

MOTHER 14. Maiden name Ruth Tunnell

15. Birthplace Chincoteague Va

16. Informant William Avery Kelley

Address Ocean City Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof aug 12, 1947 (month) (day) (year)

Cemetery or crematory Red men cemetery Va

Location Chincoteague Va

18. Funeral director Walter M. Lelash S.

Address Chincoteague Va

19. 8-11-47 (Date rec'd by registrar) Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH aug 9 1947 at 10.30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 23 1947 to aug 9 1947 and that I last saw h[illegible] alive on aug 9 1947

Immediate cause of death	DURATION
Carcinoma of colon	6 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ____ Date of op. ____

Autopsy results ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of Injury ____ Injured at work?

23. SIGNATURE Nathaniel G. Johnson M.D. M. D. or other

Address Ocean City, Md. Date signed Aug 12 47

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 183

CERTIFICATE OF DEATH

67493

Reg. Dist. No. 355

1. PLACE OF DEATH:
County Worcester
City or town near Ocean City
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years (Berlin)
Hospital, Institution, or street address where death occurred: —
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Worcester
City or town Berlin
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Earl W. Klein

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife Ruth Klein
6.(c) If alive, give age 32 years
7. Birth date of deceased (mo., day, yr.) May 30, 1912

8. AGE: Years 35 | Months 2 | Days 13 | If less than one day ... hrs. ... min.

9. Birthplace Bellingham, Washington (Town, county, and state)
10. Usual occupation Minister
11. Industry or business
FATHER 12. Name Charles W. Klein
13. Birthplace Unknown
MOTHER 14. Maiden name Minnie Decker
15. Birthplace
16. Informant Mrs. Earl Klein
Address Berlin Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/16/47 (month) (day) (year)
Cemetery or crematory Buckingham
Location Berlin Md.
18. Funeral director Emma A. Burbage
Address Berlin Md
19. 8-16- 1947 Helen F. Hayward Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13 1947 at 2 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19... to — 19...
and that I last saw h... — alive on — 19...

	DURATION
Immediate cause of death accidental drowning	
due to Falling overboard	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of Aug. 13
Where did injury occur? Sinepuxent Bay Wor. Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Fell over board Injured at work?

23. SIGNATURE John L. Riley Def. Med. Exam.
M. D. or other
Address Snow Hill, Md Date signed Aug 15-'47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

67494

Reg. Diat. No. 353

1. PLACE OF DEATH:
County: Worcester
City or town: Campbelltown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30yrs.
Hospital, institution, or street address where death occurred:
X
How long in hospital or institution? X

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Worcester
City or town Campbelltown
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rural
(If rural, give LOCATION)
2.(a) If veteran, name war X

3.(a) FULL NAME VIRGINIA ADELE LATCHUM

3.(b) Social Security Number XX

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Vernon Latchum
6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): Nov. 27, 1880

8. AGE: Years	Months	Days	If less than one day
66	9	4	...hrs. ...min.

9. Birthplace: Snow Hill Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Housework
FATHER 12. Name: James Beachump
13. Birthplace: Md.
MOTHER 14. Maiden name: Emiline Murray
15. Birthplace: Md.
16. Informant: Mr. Vernon Latchum
Address: Bishop, Md. RFD

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 3, 1947 (month) (day) (year)
Cemetery or crematory I.O.O.F.
Location Bishopville, Maryland
18. Funeral director M. Pasha Watson
Address Selbyville, Del.
19. Sept 3 1947 Mrs Ray Berger Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 31 1947, at 8:30 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 16 1946, to August 31 1947
and that I last saw her alive on August 31 1947

Immediate cause of death	DURATION
Pulmonary Embolus	10 hours
Due to Coronary Arteriosclerosis & Hypertension.	12 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE W J Hume M.D. (M. D. or other)
Address Selbyville, Delaware Date signed 9/2/47

M

I

T

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07495

932

CERTIFICATE OF DEATH

Reg. Diat. No. 355

1. PLACE OF DEATH:

County: Worcester

City or town: Ocean City, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? few hours

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Pabelisa

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Berlin Md R.F.D.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: William Edward Massey Jr.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widower

6.(b) Name of husband or wife: Laura J. Massey

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 16, 1870

8. AGE: Years: 76 | Months: 8 | Days: 16 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Berlin Wor Co Md (Town, county, and state)

10. Usual occupation: Farmer.

11. Industry or business

FATHER — 12. Name: William E. Massey

FATHER — 13. Birthplace: Berlin Md.

MOTHER — 14. Maiden name: Mary Timmons

MOTHER — 15. Birthplace: Berlin Md.

16. Informant: Mrs. Mattie Lunstle

Address: Berlin Md R F D.

17. (Burial, cremation, or removal. Which?) Burial Date thereof: 8/27/47 (month) (day) (year)

Cemetery or crematory: Riverside

Location: Berlin Md R F D

18. Funeral director: Anna D. Burbage

Address: Berlin Md

19. 8-29-1947 (Date rec'd by registrar) Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 22 1947, at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19..... to — 19.....

and that I last saw h..... alive on — 19.....

Immediate cause of death: Myocardial degeneration of the heart — DURATION: Unknown

Due to: —

Due to: —

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John L. Riley Def. Med. Examiner M. D. or other

Address: Snow Hill, Md. Date signed: Aug 22, 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS AIB 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07496

50

Reg. Diat. No. 355

1. PLACE OF DEATH:

County: Worcester.

City or town: Ocean City.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

66 years.

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Worcester.

City or town: Ocean City.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Leah Henry Melvin.

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Widow.

6.(b) Name of husband or wife: Melvin.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 15, 1864

8. AGE:

Years	Months	Days	If less than one day
83	4	10	..... hrs. ..... min.

9. Birthplace: Berlin Worc Md R F D

(Town, county, and state)

10. Usual occupation: Housewife.

11. Industry or business

FATHER

12. Name: Levin Cropper.

13. Birthplace: Md.

MOTHER

14. Maiden name: Anne Cottrell.

15. Birthplace: Md.

16. Informant: Mrs. Charles Johnson.

Address: Ocean City Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof 8/27/47 (month) (day) (year)

Cemetery or crematory: Taylorville

Location: Berlin, Md R F D.

18. Funeral director: Anna A Burbage

Address: Berlin Md

19. 8-27 1947 (Date rec'd by registrar) Helen L Hanward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 25 1947 at 2:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 14 1947 to 25 Aug 1947 and that I last saw h. on alive on 24 Aug 1947

	DURATION
Immediate cause of death: Carcinoma of Breast	4 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Nathaniel P. Thomas M. D. or other

Address: Ocean City Date signed 26 Aug 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07497

CERTIFICATE OF DEATH

Reg. Diat. No. 355

1. PLACE OF DEATH:

County: Worcester

City or town: Berlin

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Berlin

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: James Wheatley Nicholson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept. 5, 1890

8. AGE: Years	Months	Days	If less than one day
56	11	0	hrs. min.

9. Birthplace: Berlin Worc Co Md R F D

(Town, county, and state)

10. Usual occupation: merchant

11. Industry or business

FATHER — 12. Name: John W. Nicholson

13. Birthplace: Md.

MOTHER — 14. Maiden name: Lizzie B Bradford

15. Birthplace: Md.

16. Informant: Mrs. Carl Jarman

Address: Chincoteague Va

17. (Burial, cremation, or removal. Which?) Burial, Date thereof 8/5/47 (month) (day) (year)

Cemetery or crematory: Riverside

Location: Berlin Md R F D

18. Funeral director: Anna A. Bunting

Address: Berlin Md.

19. 8/8 (Date rec'd by registrar) 1947 Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5 Aug 1947 at 7 45 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1947, to 5 Aug 1947 and that I last saw h[illegible] alive on 5 Aug 1947

Immediate cause of death	DURATION
Acute intestinal obstruction	2 days
Due to: Incarcerated Inguinal Hernia, left side indirect	
Due to: complete, rectal	
Other conditions: Pneumonia, Emetine, mucl	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: H. A. Phillips M.D. M. D. or other

Address: Berlin, Md. Date signed 7 Aug 47

M

I

T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

07498

CERTIFICATE OF DEATH

Reg. Dist. No. 351

1. PLACE OF DEATH:
County: Worcester
City or town: Snow Hill
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5-9 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Snow Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: William S. Parsons

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 9 - 1870

8. AGE: Years	Months	Days	If less than one day
77	7	15	..... hrs. ..... min.

9. Birthplace: Salisbury, Wicomico, Md
(Town, county, and state)
10. Usual occupation: Retired Banker
11. Industry or business:

FATHER
12. Name: Robert E. Parsons
13. Birthplace: Maryland

MOTHER
14. Maiden name: Julia A. Truitt
15. Birthplace: Maryland

16. Informant: Mrs. William T. Purnell
Address: Snow Hill, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 26/47 (month) (day) (year)
Cemetery or crematory: Presbyterian
Location: Snow Hill, Md

18. Funeral director: Clay E. Timmis
Address: Snow Hill, Md

19. 8/26 47 19 ..... R. Day Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 24 19 47, at 6 45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/2 47 19 to 8/24/47 19 and that I last saw him alive on 8/24/47 19

	DURATION
Immediate cause of death: Erysipelas	2 mo
Due to: Arteriosclerosis	unknown
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ..... Injured at work?

23. SIGNATURE: Paul Shen M.D.
M. D. or coroner
Address: Snow Hill Date signed: 8/26/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

07499

CERTIFICATE OF DEATH

Reg. Diat. No. 355

1. PLACE OF DEATH:

County Worcester

City or town Berlin R F D

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 years.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Worcester.

City or town Berlin R F D.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME John Wesley Powell

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single.

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 5, 1912

8. AGE: Years	Months	Days	If less than one day
35	0	4	..... hrs. ..... min.

9. Birthplace Berlin Wor Co Md R F D

(Town, county, and state)

10. Usual occupation Carpenter.

11. Industry or business

FATHER 12. Name John J Powell.

13. Birthplace Maryland.

MOTHER 14. Maiden name Annie Truitt.

15. Birthplace Maryland.

16. Informant Mrs. John J Powell.

Address Berlin Md R F D

17. Burial

(Burial, cremation, or removal. Which?) Date thereof 5/12/47 (month) (day) (year)

Cemetery or crematory Odd Fellows

Location Bishopville Md

18. Funeral director Bruce A. Burbage

Address Berlin Md

19. 5/12 1947 Helen F. Hayward Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-4-47 19..... at 1 30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-15-47 19..... to 5-4-47 19.....

and that I last saw h. Living alive on 5-5-47 19.....

Immediate cause of death	DURATION
Chronic Dist. Nephritis	
Due to Hypertension	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

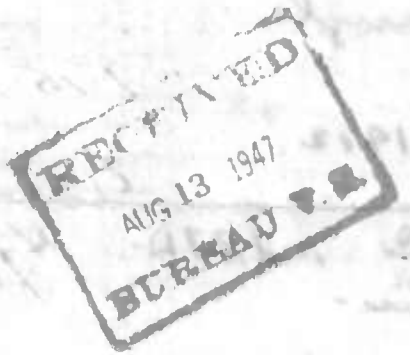
23. SIGNATURE Clifford E. Lukens M. D. or other

Address Berlin Md Date signed .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M


RECEIVED
AUG 13 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07500

136

CERTIFICATE OF DEATH

Reg. Diat. No. 355

1. PLACE OF DEATH:

County Worcester

City or town Berlin

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Worcester

City or town Berlin

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war World War I

3.(a) FULL NAME Clifford Henry Purnell.

3.(b) Social Security Number 171-10-9149

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married.

6.(b) Name of husband or wife Virginia Purnell

6.(c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) April 4, 1896

8. AGE:

Years	Months	Days	If less than one day
50	4	13	....hrs. ....min.

9. Birthplace Berlin Wor Co Md.

(Town, county, and state)

10. Usual occupation Laborer.

11. Industry or business

FATHER

12. Name George Timmons

13. Birthplace Md.

MOTHER

14. Maiden name Addie B. Purnell

15. Birthplace Md

16. Informant Mrs Clifford Purnell

Address Berlin Md

17. Buried Date thereof 5/20/47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St Pauls.

Location Berlin Md

18. Funeral director Anna A Burbage

Address Berlin Md

19. 8-19 1947 Helen E. Hayward

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 17 Aug 1947 at 2 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1947 to 17 Aug 1947 and that I last saw h... alive on 13 Aug 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	3 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ....Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ....Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Leonard Hubbard M. D. or other

Address Berlin, Md. Date signed 20 Aug 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

07501

Reg. Dist. No. 855

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS

1. PLACE OF DEATH:

County: Worc

City or town: Ocean City Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mos.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Delaware County: Sussex

City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Ernest Purnell

3.(b) Social Security Number: none

4. Sex: male

5. Color or race: white

6.(a) Single, married, widowed, or divorced: married

6.(b) Name of husband or wife: Jennie Purnell

6.(c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): August 25 1869

8. AGE: Years: 78 Months: 11 Days: 26 If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Retired Hotel operator

11. Industry or business:

FATHER
12. Name: Samuel Purnell
13. Birthplace: Maryland

MOTHER
14. Maiden name: Addie Ennis
15. Birthplace: Maryland

16. Informant: Jennie Purnell
Address: Laurel, Del.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 23-47 (month) (day) (year)
Cemetery or crematory: Presbyterian Cemetery
Location: Snow Hill, Md.

18. Funeral director: G. S. Windsor
Address: Laurel Del.

19. 8-23 1947 (Date rec'd by registrar) Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 20 1947 at 5:50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 4 1947, to Aug 20 1947 and that I last saw him alive on Aug 20 1947

Immediate cause of death	DURATION
Respiratory failure	
Due to: Cerebral thrombosis	3 hrs.
Due to: Arterio sclerotic C.V.D.	4 years.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: H. Townsend M. D.
M. D. or other

Address: Ocean City, Md. Date signed: Aug 20, 47.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

61

07502

Reg. Dist. No. 351

1. PLACE OF DEATH:
County: Worcester
City or town: Snow Hill Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Big months
Hospital, institution, or street address where death occurred: no
How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Worcester
City or town: Snow Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No. no
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: Alfred Robinson

3.(b) Social Security Number: 221-09-3884

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	a. a.	Married

6.(b) Name of husband or wife: Mary E Robinson
Dead 6.(c) If alive, give age: no years

7. Birth date of deceased (mo., day, yr.): about 1887

8. AGE: Years: about 60 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Norfolk Va.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Same as above

FATHER
12. Name: Bloxch Robinson
13. Birthplace: Warrington Va.

MOTHER
14. Maiden name: Harriet Sullivan
15. Birthplace: Warrington Va.

16. Informant: Harriet Boone
Address: Snow Hill, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 5 1947 (month) (day) (year)
Cemetery or crematory: Mt Wesley
Location: Snow Hill Md.

18. Funeral director: James F Stewart
Address: Salisbury Md.

19. 8/4 1947 (Date rec'd by registrar) L. Day Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 1 1947 8 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 1947 to Aug 1 1947
and that I last saw him alive on July 29 1947

	DURATION
Immediate cause of death: Acute Pulmonary Edema	3 days
Due to: Hypertensive Cardiovascular renal disease	10 yrs
Due to:	
Other conditions: Diabetes Mellitus	10 yrs

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert L. LaMar MD
M. D. or other
Address: Snow Hill Date signed: 8-2-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

07503

CERTIFICATE OF DEATH

Reg. Dist. No. 353

1. PLACE OF DEATH:
County: Worcester
City or town: Bishopville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Bishopville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: No #
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Harry Thomas Smith

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Marion E. Smith
6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): March 18, 1889

8. AGE: Years: 58 | Months: 4 | Days: 19 | If less than one day: hrs. min.

9. Birthplace: Bishopville Md.
(Town, county, and state)

10. Usual occupation: Engineer

11. Industry or business: "

FATHER
12. Name: Thomas J Smith
13. Birthplace: Md.

MOTHER
14. Maiden name: Martha Murray
15. Birthplace: Md.

16. Informant: Marion E. Smith
Address: Bishopville. Md.

17. Burial, cremation, or removal. Where? Burial Date thereof: Aug 10, 1947
(month) (day) (year)
Cemetery or crematory: I.O.O.F.
Location: Bishopville Md.

18. Funeral director: M. Pasha Watson
Address: Selbyville, Del.

19. 8/8 19 47 Mrs Roy Bunting
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 7 19 47, at 7 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 28 19 47, to Aug 7 19 47
and that I last saw h... alive on Aug 7 19 47

Immediate cause of death	DURATION
Coronary thrombosis	2 days.
Due to Arterio-sclerotic heart disease	5
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

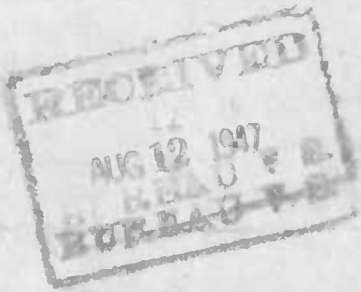
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Robert S. Berg M.D.
M. D. or other
Address: Frankford, Del. Date signed: 8-8-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


RECEIVED
AUG 12 1947
BUREAU OF R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

07504

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH:
County: Worcester
City or town: Pocomoke
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 years.
Hospital, Institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Maryland County: Worcester
City or town: Pocomoke City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 203 Bonniville Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Blanche T. Sturgis

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: James Sturgis
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Oct 28-1878

8. AGE: Years: 68 Months: 9 Days: 7 If less than one day: ____ hrs. ____ min.

9. Birthplace: Fairmount Somerset Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: —

FATHER
12. Name: William H. Thompson
13. Birthplace: Maryland

MOTHER
14. Maiden name: unknown
15. Birthplace: "

16. Informant: Mrs Mabel Phillips
Address: Pocomoke Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 8-1947 (month) (day) (year)
Cemetery or crematory: Salem M.E. Cemetery
Location: Pocomoke City Md.

18. Funeral director: Henry S. Watson
Address: Pocomoke Md

19. Aug 7, 1947 (Date rec'd by registrar) Anne E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 5 1947 at 8.30 a M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 19____ to Aug 3rd 1947
and that I last saw her alive on Aug 3rd 1947

	DURATION
Immediate cause of death: a Nephritis	4 days
Due to:	
Due to:	
Other conditions: Diabetes Mellitus	Unk. 10 yrs +

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. ____
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE: N. E. Santoriens M. D. or other
Address: Pocomoke City Md. Date signed 8/5/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for the change of age is shown on G 111 8/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

07505

CERTIFICATE OF DEATH

Reg. Diat. No. 355

1. PLACE OF DEATH:

County: Worcester

City or town: Ocean City

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Worcester.

City or town: Ocean City

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Luther Francis Tilghman.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married.

6.(b) Name of husband or wife: Rose C. Tilghman

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 22, 1903

8. AGE: Years: 44 4/5 | Months: 5 | Days: 17 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Wilmington Del. (Town, county, and state)

10. Usual occupation: painter + cook.

11. Industry or business

FATHER — 12. Name: James Tilghman

FATHER — 13. Birthplace: Maryland.

MOTHER — 14. Maiden name: Jarrett Lewis.

MOTHER — 15. Birthplace: Maryland

16. Informant: Mrs Rose C. Tilghman

Address: Ocean city Md

17. (Burial, cremation, or removal. Which?) Burial — Date thereof: 8/12/47 (month) (day) (year)

Cemetery or crematory: Evergreen (Col.)

Location: Berlin Md

18. Funeral director: Irma A. Burbage

Address: Berlin Md.

19. 8-12-47 (Date rec'd by registrar) Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 9 19 47 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 7 19 47, to Aug 9 19 47, and that I last saw h... alive on Aug 8 19 47.

Immediate cause of death	DURATION
Heart failure	
Due to: Cerebral hemorrhage	3 days
Due to: Hypertensive C.V.D.	Unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: H Townsend (M.D.)

Address: Ocean City, Md. M.D. or other

Date signed: Aug 11/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07506

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH:

County: Worcester

City or town: Berlin

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 29 years.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Worcester

City or town: Berlin

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Elizabeth Easton Verbrycke.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married.

6.(b) Name of husband or wife: Dr. J. Russell Verbrycke

6.(c) If alive, give age: 86 years

7. Birth date of deceased (mo., day, yr.): April 29, 186x

8. AGE:

Years	Months	Days	If less than one day
83	3	10	...hrs. ...min.

9. Birthplace: Belvidere Illinois
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: Thomas Chalmers Easton

13. Birthplace: Scotland

MOTHER

14. Maiden name: Cornelia Hoff.

15. Birthplace: N. J.

16. Informant: Dr. J. Russell Verbrycke

Address: Berlin Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/11/47 (month) (day) (year)

Cemetery or crematory: Buckingham

Location: Berlin Md

18. Funeral director: Dana A. Burbage

Address: Berlin Md

19. 8-11" 1947 (Date rec'd by registrar) Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9 Aug 1947 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5 Feb 1947 to 9 Aug 1947 and that I last saw h... alive on 9 Aug 1947

Immediate cause of death	DURATION
Chronic Degenerative Myocarditis & Cor Pulmonale	
Due to: Acute Bronchial	2 Yrs
Due to: Chronic Bronchitis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ... Injured at work?

23. SIGNATURE: H. Hadden Dean M. D. or other

Address: Berlin, Md. Date signed 8/11/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M